NAME OF PROVIDER OR SUPPLIER CREEKSIDE HEALTH AND REHABILITATION C STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115 (XAUD SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	Division of Health Care Fac STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		COM	(X3) DATE SURVEY COMPLETED C 06/16/2016	
CREEKSIDE HEALTH AND REHABILITATION C (X4)ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS N 000 Initial Comments During complaint investigation of #38845, #38850, and #38920 conducted 5/16/16 through 6/16/16, at Creekside Health and Rehabilitation Center, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.			TN1939					
CREEKSIDE HEALTH AND REHABILITATION MADISON, TN 37115 SUMMARY STATEMENT OF DETICIENCIES RECOLATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments During complaint investigation of #38845, #38850, and #38820 conducted 5/16/16 through 6/16/16, at Creekside Health and Rehabilitation Center, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
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ision of Health Care Facilities 30 RATERY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE		During complaint in #38850, and #3892 6/16/16, at Creeksic Center, no deficient the complaints under	to conducted 5/16/16 through de Health and Rehabilitation cies were cited in relation to	N 000				
	sion of Hea	alth Care Facilities	PRISUPPLIER REPRESENTATIVE'S SIG	NATURE -	TITLE	1	(X6) DATE	

STATE FORM

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